Committee Report

To: Chair Burley and Members of the Long Term Care Committee of Management

Committee Date: January 4, 2018

Subject / Report No: LTCR-CM-06-18

Title: Ministry of Health and Long Term Care Updates—New Interview Guidelines and Memo to the Sector of October 2017

Prepared by: Lynne Johnson, Director of Long Term Care

Reviewed by: Kim Wingrove, Chief Administrative Officer

Lower Tier(s) Affected: All Grey County

Status: Recommendation adopted by Committee as amended per Resolution CM17-18; Endorsed by County Council January 11, 2018 per Resolution CC14-18;

Recommendation

1. That report LTCR-CM-06-18 regarding Long Term Care Sector Updates from the Ministry of Health and Long Term Care be received for information.

Background and Discussion

Updates to the long term care sector are provided to clarify existing policy or provide notice of changes (pending/actual). Two recent documents and an attachment were recently circulated to the sector. They are referenced below.

Conducting Interviews Guidance Document

On November 7, 2017 the Ontario Long Term Care Association provided the homes with a document from the Ministry of Health and Long Term Care, “Conducting Interviews Guidance Document”. The guidelines were created as a result of the OLTMCA Quality Committee identifying sector concerns with the tone and approach of some inspectors and the disruptive effects on the staff and home operations. The guidance document outlines the:

- Expectations of the Inspectors
- Expectations of Staff
- Reminders when conducting an interview
- Rationale/Additional Detail
It is our understanding that the document was recently distributed to all long term care home inspectors. The guidelines will be used in the home as an education tool to support open communication with the inspectors and clarify responsibilities of all parties.

**LTC Homes Memo to the Sector- October 2017**

This memo from the Ministry of Health and Long Term Care Branch provides several sector specific updates and reminders for programs and services within the homes including:

- Information on a new leading practices database
- Update on Bed Rail Safety
- Responsive Behaviours
- Personal Support Worker Credentialing
- Dementia and New Quality Standards
- Clarification of Mandatory and Critical Incident Reporting Requirements

Each update will be reviewed and assessed against current practices.

Notable within this memo was the recirculation of a Mandatory and Critical Incident Reporting Requirements memo dated February 10, 2015. Questions have been raised in the past from Committee and Council regarding incidents. This memo provides an overview of the expectations, process, method and time-frame for reporting critical incidents.

**Legal and Legislated Requirements**

There is a very high focus on accountability and compliance within long term care homes and the *Long Term Care Homes Act, 2010 and Ontario Regulation 79/10* provide the criteria which must be met. Each organization works to interpret the requirements under the Act and Regulation however the interpretation may not be the same as the interpretation of the Compliance Inspector. To meet legislative requirements it is imperative that organizations have the ability to review research and collaborate in a nimble fashion to respond to needs and changes in a timely manner.

**Financial and Resource Implications**

Sector expectations, changes and updates come from a wide variety of legislative bodies and professional organizations including the Ministry of Health and Long Term Care, South West Local Health Integration Network and the Ontario Long Term Care Association.

The number of competing priorities continues to grow and staff work diligently to review changes (proposed and actual), understand the impact, research and update policies/procedures and roll out education and communication to the appropriate staff.

**Relevant Consultation**

- Internal
  - Administrators of Grey Gables, Lee Manor and Rockwood Terrace.
Appendices and Attachments

Documents as follows:

1) Conducting Interviews Guidance Document
2) LTCHomes.net Memo to the Sector
3) Memorandum- Clarification of Mandatory and Critical Incident Reporting Requirements
Conducting Interviews Guidance Document
Long-Term Care Quality Inspection Program
July 26, 2017

Introduction
Inspectors are required to conduct inquiries and inspections in order to collect evidence for the purposes of ensuring compliance with the requirements under the Long-Term Care Homes Act, 2007. Crucial information is gathered while conducting interviews to ensure that findings of non-compliance are comprehensive and accurate.

This guidance document has been developed to assist inspectors in the Long-Term Care Homes Quality Inspection Program, as well as staff in long-term care homes (LTCH), in Ontario, in preparing for and conducting inspector interviews.

For the purposes of this document, LTCH staff are referred to as the interviewee.

Expectations for all Interviews
Each interview must be conducted using the values and elements of professionalism, including but not limited to:

- Honesty and Integrity
- Confidentiality
- Respect
- Timeliness
- Objectivity
- Knowledge

<table>
<thead>
<tr>
<th>Expectations of Inspectors</th>
<th>Expectations of LTCH Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Introduce themselves and explain the purpose of the interview.</td>
<td>• Introduce themselves and identify their position and role in the care team.</td>
</tr>
<tr>
<td>• During the interview, use good interpersonal skills which include smiling upon introduction, using effective communication and good listening skills.</td>
<td>• Respond in a professional manner</td>
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</table>
## Conducting the Interview

<table>
<thead>
<tr>
<th>Reminders</th>
<th>Rationale/Additional Detail</th>
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| Determine if it is a convenient time for the interviewee | • To avoid unnecessary disruptions to resident care or other routines, noting there may be times when an immediate interview is required.  
• If it is possible the interview will be conducted at a mutually agreed upon time. |
| Face to face interviews | • Preferred for interviewing LTCH staff and residents, witnesses to alleged abuse or when conducting interviews related to contentious issues. |
| Telephone interviews | • Appropriate for conducting inquiries, contacting complainants, family members and staff of the LTCH who are not on duty in the LTCH during an inspection.  
• Ensure that the time is also convenient and that the interviewee is able to communicate safely (e.g. not while driving) and with privacy.  
• If an interviewee is not able to communicate safely, they must communicate this to the Inspector. |
| If speaking with a staff member who is not on duty in the LTCH | • If this is required, the Inspector would review the schedule to see when the staff member is working next and if they will not be in the LTCH prior to the completion of the inspection, the Inspector would request the staff member’s phone number from the LTCH.  
• The Inspector will call the staff member at the number provided by the LTCH and set up a convenient time for an interview.  
• The Inspector must provide the reason for the interview and if necessary, provide their authority for the request.  
• Requests for interviews, with a staff member who is not on duty in the LTCH, will be made to provide required information, when circumstances warrant.  
• LTCH staff members must cooperate with the request for interviews. |
| Interview one interviewee at a time | • As per best practice, an Inspector should not interview more than one interviewee at a time.  
  e.g. Do not interview the Administrator and the Director of Nursing and Personal Care together in one interview; separate their interviews. |
| Interviewees should only provide information that | • During face to face or telephone interviews, the Inspector must advise the interviewee that he/she is able to consult |
| **they can personally substantiate** | any relevant documentation or records as needed to corroborate accuracy of information provided during the interview. Once an inspector notifies an interviewee that an interview is required, the interview will take place as soon as reasonably possible in order to ensure the integrity of the evidence gathering process.  
- Interviewees must inform the Inspector of the need to consult relevant documentation or records.  
- The Inspector may need to schedule a follow-up interview once the interviewee has consulted relevant documents or records.  
- Inspectors should remind interviewees not to discuss the scope or content of their interview with other people. |
<table>
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</tr>
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<tbody>
<tr>
<td><strong>Interviewee has confirmed the accuracy of the information</strong></td>
<td>For both face to face or telephone interviews, the Inspector must confirm this before the interview is over and allow an opportunity for the interviewee to amend any errors.</td>
</tr>
<tr>
<td><strong>Provide the Inspector’s contact information to the interviewee</strong></td>
<td>Contact information to be provided should any follow-up be required.</td>
</tr>
</tbody>
</table>
| **Inspector requires access to documented information** | There may be times when an Inspector requires access to documented information to verify facts of an interview.  
- The Ministry requires LTCH's to provide Inspectors with timely remote access (if available) so that Inspectors are able to access information using their own computer. Inspectors must not use the remote access when they are not on-site in the LTCH. |

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1. Regulator's Code of Practice: Integrity in Pursuit of Compliance  
2. LTCHA, 2007, c.8, s. 147(1)(d).
IN THIS MEMO

Leading Practices Database, a Tool for LTC Homes
Health Canada Safety Alert – Bed Rail Safety
Meeting the Needs of Residents with Responsive Behaviours
PSW Certification
Quality Standards: Behavioural Symptoms of Dementia
Clarification of Mandatory and Critical Incident Reporting Requirements

LEADING PRACTICES DATABASE, A TOOL FOR LTC HOMES

Canadian long-term care home operators have a wealth of knowledge on how to deliver top quality care for residents. There is now a free online database that features over one thousand recognized leading practices that you can use to improve operations in your home.

The Leading Practices Database features an advanced search function that makes it easy to sift through information on a wide variety of topics including managing medication, client rights and consent, patient safety, workplace safety, and mental health services to name just a few.

Accreditation Canada is pleased to share this database and they also invite your contributions to make the tool even more robust and informative. If you would like to suggest a leading practice for inclusion in the database, take a look at the easy online submission process.

Visit the database here: https://healthstandards.org/leading-practices/

HEALTH CANADA SAFETY ALERT – BED RAIL SAFETY

Health Canada continues to receive reports of patient entrapment in beds, with some incidents leading to serious injury or death. It is important for staff to perform a resident assessment to determine if the use of bed rails is appropriate for each individual and to closely monitor residents for whom bed rails are used.

Here is an excerpt from the Health Canada letter on what to consider when doing a patient assessment for the use of bed rails.

- Patient mental status (oriented, alert, confused, drowsy, disoriented, unconscious)
- Patient mobility status (immobile vs. complete independence)
- Patient risk of fall (previous falls, overweigh, partial paralysis, seizures or spasms)
- Risk of fall injuries (oedema, osteoporosis, fragile skin, vascular disease, critically ill)
- Patient anxiety level upon bed rail use
- Patient medications

Note: S. 15(1)(a) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 addresses the requirement for a resident to be assessed where bed rails are used.

The following links will help you learn more about the issue of bed rails and entrapment risk.

- Health Canada Letter to Health Care Professionals
- Health Canada article on hospital bed safety
MEETING THE NEEDS OF RESIDENTS WITH RESPONSIVE BEHAVIOURS

Every licensee of a long-term care home has an obligation under O. Reg. 79/10, s. 53(1) to take specific measures to ensure that the needs of residents with responsive behaviours are met. There is also a need to reassess these measures when persistent physical aggression is seen. This particular issue was addressed by a recent meeting of the Geriatric and Long-Term Care Review Committee.

The expectation is that long-term care homes will use all available resources to address residents' responsive behaviours. These resources include:

- Services offered through Behavioural Supports Ontario,
- The High Intensity Needs Fund program,
- Specialized units,
- Behavioural outreach teams
- Specialized Geriatric Services

In accordance with the LTCHA and Regulation, homes must provide residents with the care they require, based on assessed needs, as set out in residents' plans of care. In meeting the needs of residents with responsive behaviours, LTC homes are required to have resident monitoring and internal reporting protocols, as well as protocols for the referral of residents to specialized resources where required. These are in addition to other responsive behaviour-related requirements set out in the Act and Regulation.

PSW CERTIFICATION

Homes should be aware of a recent notice sent out by the National Association of Career Colleges (NACC) that there have been reports of Personal Support Workers using fraudulent certificates.

We are told that legitimate PSW certificates will bear the NACC watermark in the background and that the signature fields for the school and the NACC will be filled. Also, the date of the certificate will always be listed in one of the following formats:

- October 2017
- October 30, 2017 (always the last day of the month)

QUALITY STANDARDS: BEHAVIOURAL SYMPTOMS OF DEMENTIA

Health Quality Ontario recently published new quality standards that address care for people living with dementia and the specific behaviours of agitation and aggression.

The quality standard focuses on care for people who are in a long-term care home, an emergency department, or admitted to a hospital. It also provides guidance on the care given when a person is transitioned between these settings – for example, when someone is discharged from a hospital to a long-term care home.

Also, there are a number of other dementia-related resources also available on the HQO website.
CLARIFICATION OF MANDATORY AND CRITICAL INCIDENT REPORTING REQUIREMENTS

Long-term care home staff must be familiar with the mandatory and critical incident reporting requirements set out in the Long Term Care Homes Act, 2007.

We would like to remind staff and licensees of these requirements by way of the attached memo that was previously distributed in February 2015. Please take the time to review the information to ensure your home’s processes are in line with the expectations and requirements under the Act.

In addition, we also want to remind all licensees that in accordance with section 20 of the Act, all licensees must have a written policy in place to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is complied with. That written policy must include an explanation of the duty under section 24 to make mandatory reports to the Director as well as meet other minimum requirements set out in section 20 of the Act.

This means that there needs to be a process outlined within the policy to ensure that any staff member or representative of the licensee who has reasonable grounds to suspect that any of the areas outlined in section 24(1) of the Act has occurred or may occur, participates in the process of immediately reporting the suspicion and information upon which it is based to the Director and that there is a process set out to enable that to happen.

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DATE: February 10, 2015

MEMORANDUM TO: Long-Term Care Home Licensees
Long-Term Care Home Administrators

FROM: Nancy Lytle
Director
Performance Improvement and Compliance Branch

RE: Clarification of Mandatory and Critical Incident Reporting Requirements

The Long-Term Care Homes Act, 2007 (LTCHA) and Ontario Regulation 79/10 (Regulation) contain mandatory and critical incident reporting requirements for licensees. The purpose of this memorandum is to identify the form in which the Director requires that every licensee submit these reports to the Director. Licensees are required to submit the reports identified in this memorandum in the form set out in this memorandum and its appendices pursuant to subsection 88(2) of the LTCHA. This memo:

- updates the memorandum dated August 4, 2010 from Tim Burns, former Director, by clarifying the reporting of Critical Incidents under section 107 of the Regulation, along with a reminder of the mandatory reporting requirements to the Director under subsection 24(1) of the LTCHA;
- is a reminder of the licensee’s obligation to report its investigations of alleged, suspected or witnessed incidents of abuse or neglect of residents under section 23 of the LTCHA; and
- is a reminder of the actions to be taken by licensees or others in relation to the reporting requirements, including the timeframe of the final report under subsection 104(3) of the Regulation, as previously outlined in the memorandum of March 28, 2012, from Karen Slater, former Director (Â).

This memorandum contains a summary of the specified reporting requirements in the LTCHA and its Regulation. Please refer to the LTCHA and the Regulation for the complete requirements.

It is the licensee’s responsibility to ensure that this information is provided to all staff who are expected to report on the licensee’s behalf.

LTCHA, Subsection 24(1) – ‘Reporting Certain Matters to the Director’

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which is based to the Director:

.../2
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident’s money.
5. Misuse or misappropriation of funding provided to a licensee under the Act or the Local Health System Integration Act, 2006.

How to Report Under Section 24

TABLE 1 in Appendix A, attached, sets out how licensees, including those individuals reporting on behalf of a licensee, must submit mandatory reports under section 24 of the LTCHA to the Director.

LTCHA, section 23 – Licensee must investigate, respond and act; and Regulation, section 104 – Licensees who report investigations under subsection 23(2) of the Act

The licensee is required to investigate alleged, suspected or witnessed incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff that are known by or reported to the licensee (see section 23 of the LTCHA). (Please refer to the definitions of abuse and neglect set out in subsection 2(1) of the LTCHA and section 2 of the Regulation.) Appropriate action must be taken in response to these incidents. The licensee must report to the Director the results of the investigation and the action(s) taken. This report to the Director must be in writing and section 104 of the Regulation sets out what information must be included in the report. Licensees must submit this report to the Director within 10 days of the licensee becoming aware of the incident or at an earlier date if required by the Director. If the licensee cannot provide all of the material mandated by subsection 104(1) then the licensee must submit a preliminary report to the Director within 10 days of the licensee becoming aware of the incident and must provide a final report within a period of time specified by the Director. In a separate memo dated March 28, 2012 the Director identified that the final report must be submitted in 21 days unless otherwise specified by the Director.

How to Report Under Section 23

Licensees must submit the reports required by section 23 of the LTCHA and section 104 of the Regulation through the on-line Critical Incident System (CIS) using the CIS form.

Additional Clarification Regarding Reporting of Abuse of Residents

In determining whether a mandatory report under section 24 relating to abuse or neglect of a resident is required, or if section 23 applies, LTC Home licensees and staff should review the definitions of abuse and neglect as set out in subsection 2(1) of the LTCHA and section 2 of the Regulation. The definitions in force as of the date of this memo are outlined below.

LTCHA, section 2(1):
“Abuse”, in relation to a resident, means physical, sexual, emotional, verbal or financial abuse, as defined in the regulations in each case", and

Regulation, section 2, (1)
“emotional abuse” means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

“financial abuse” means any misappropriation or misuse of a resident’s money or property.

“physical abuse” means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

**Note:** “physical abuse” is this subsection does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. Regulation s. 2 (2).

“sexual abuse” means,
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

**Note:** Sexual abuse in this subsection does not include,
(a) touching, behaviour or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living; or
(b) consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member. Regulation s. 2 (3).

“verbal abuse” means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

“neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Under section 24 of the LTCHA, licensees are NOT required to report an assault on a staff member by a resident. Although licensees may not have to report these incidents under the LTCHA, licensees may be required to, or should report these incidents to other persons or entities, such as the Ministry of Labour or the police.

**Reporting Critical Incidents**
This reporting is outlined under section 107 of the Regulation.
Regulation, subsection 107(1) – report of critical incident immediately
The following critical incidents must be reported to the Director immediately, in as much detail as is possible in the circumstances, followed by the written report referred to in subsection 107(4) – refer to Appendix B:
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply.

Regulation, subsection 107(3) – report of critical incident within one business day
The following critical incidents in the home must be reported to the Director within one business day after occurrence of the incident, followed by the written report referred to in subsection 107(4) – refer to Appendix B:
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including: a breakdown or failure of the security system; a breakdown of major equipment or a system in the home; a loss of essential services, or flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident’s health condition.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

Regulation, subsection 107(2) - reports
For reporting purposes, the Ministry’s normal business hours are 8:30 a.m. – 4:30 p.m. After normal business hours, the immediate report of the incidents listed in subsection 107(1) of the Regulation must be made using the Ministry’s after hours emergency contact (Spills Action Centre (SAC) pager). This pager number is only to be used by LTC Home licensee/staff and only for purposes of after-hours reporting on behalf of the licensee.

Where the licensee is required to report a critical incident to the Director under subsections 107 (1), (3) and (3.1), the licensee must make a report in writing to the Director within 10 days of the licensee becoming aware of the incident or at an earlier date if required by the Director. This report must include all of the information set out in subsection 107(4) of the Regulation. The licensee must submit this report to the Director using the on-line Critical Incident System form.

Summary of the Regulation Amendments Affecting Critical Incident Reporting, Effective September 15, 2013
The Regulation was amended to remove “loss of essential services” and “flooding” from the list of emergencies that must be reported immediately. These incidents were added to the list of environmental hazards that must be reported within one business day.

The reporting requirements for environmental hazards were clarified so that the reporting requirements apply to incidents that affect the provision of care or the safety, security or well-being of one or more residents of a LTC home, for a period greater than six hours.
The reporting requirements related to injuries were amended so that reporting is only required no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident’s health condition. The term “significant change” is defined in the Regulation (see subsection 107(7) of the Regulation). If the LTC home licensee is unable within one business day to determine whether the injury has resulted in a significant change in the resident’s health condition, the licensee must contact the hospital within three calendar days after the incident to determine whether the injury resulted in a significant change (see subsection 107(3.1) of the Regulation). If the licensee finds out that the injury has resulted in a significant change in the resident’s health condition or the licensee remains unable to determine whether this is the case, the licensee must inform the Ministry of the incident no later than three business days after the incident occurred. The licensee must follow with the report required under subsection 107(4).

How to Report Under Section 107

TABLE 2 in Appendix B, attached, sets out how the licensee, and others on behalf of the licensee, must submit to the Director the reports required by section 107 of the Regulation.

If you have further questions related to this memorandum, please email your question to CIATTgeneral.MOH@ontario.ca with the subject line “CIS Reporting Question”. Thank you for your attention to this matter.

Nancy Lytle
Attachment
### Appendix A: TABLE 1: LTCHA Subsection 24(1) – Reporting Certain Matters to the Director

<table>
<thead>
<tr>
<th>Type of Incident in LTC Home</th>
<th>Section of the LTCHA</th>
<th>How Licensee must submit report to MOHLTC (Director)</th>
<th>Reporting Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident</td>
<td>LTCHA s.24(1).1</td>
<td>Immediately initiate and submit the on-line Critical Incident System (CIS) form identifying this as a “Mandatory Report”</td>
<td>Immediately upon having reasonable grounds to suspect this has occurred or may occur</td>
</tr>
<tr>
<td>Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident</td>
<td>LTCHA s.24(1).2</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a “Mandatory Report”</td>
<td>Immediately upon having reasonable grounds to suspect this has occurred or may occur</td>
</tr>
<tr>
<td>Unlawful conduct that resulted in harm or a risk of harm to a resident</td>
<td>LTCHA s.24(1).3</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a “Mandatory Report”</td>
<td>Immediately upon having reasonable grounds to suspect this has occurred or may occur</td>
</tr>
<tr>
<td>Misuse or misappropriation of a resident’s money</td>
<td>LTCHA s.24(1).4</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a “Mandatory Report”</td>
<td>Same as Monday-Friday</td>
</tr>
<tr>
<td>Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006</td>
<td>LTCHA s.24(1).5</td>
<td>Immediately initiate and submit the on-line CIS identifying this as a “Mandatory Report”</td>
<td>Same as Monday-Friday</td>
</tr>
</tbody>
</table>

*Note: Phone the After Hours Pager # and immediately notify MOHLTC (Director) when a report is submitted.*
Appendix B: TABLE 2: Critical Incident Reporting under O Reg 79/10 subsections 107(1), (3), (3.1), and (7)

<table>
<thead>
<tr>
<th>Type of Incident in LTC Home</th>
<th>Section of O Reg 79/10</th>
<th>How Licensee must submit report to MOHLTC (Director)</th>
<th>Reporting Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>An emergency, including fire, unplanned evacuation or intake of evacuees.</td>
<td>s.107(1).1.</td>
<td>Immediately initiate and submit the on-line Critical Incident System (CIS) form identifying this as a ‘Critical Incident’.</td>
<td>Phone the After Hours Pager # [redacted] immediately; full report within 10 days of becoming aware of the incident°</td>
</tr>
<tr>
<td>An unexpected or sudden death, including a death resulting from an accident or suicide.</td>
<td>s.107(1).2.</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a ‘Critical Incident’.</td>
<td>Phone the After Hours Pager # [redacted] immediately; full report within 10 days of becoming aware of the incident°</td>
</tr>
<tr>
<td>A resident who is missing for three hours or more.</td>
<td>s.107(1).3.</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a ‘Critical Incident’.</td>
<td>Phone the After Hours Pager # [redacted] immediately; full report within 10 days of becoming aware of the incident°</td>
</tr>
<tr>
<td>Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.</td>
<td>s.107(1).4.</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a ‘Critical Incident’.</td>
<td>Phone the After Hours Pager # [redacted] immediately; full report within 10 days of becoming aware of the incident°</td>
</tr>
<tr>
<td>An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.</td>
<td>s.107(1).5.</td>
<td>Immediately initiate and submit the on-line CIS form identifying this as a ‘Critical Incident’.</td>
<td>Phone the After Hours Pager # [redacted] immediately; full report within 10 days of becoming aware of the incident°</td>
</tr>
<tr>
<td>Contamination of the drinking water</td>
<td>s.107(1).6.</td>
<td>Immediately initiate and</td>
<td>Phone the After Hours Pager # [redacted] immediately; full report within 10 days of becoming aware of the incident°</td>
</tr>
</tbody>
</table>

°Please ensure that the staff person reporting abuse of a resident has reviewed the definitions of abuse set out in the LTCRA, subsection 2(1) and the Regulation, section 2.

Any person who is aware of an incident that must be reported to the Director under subsection 24(1) of the LTCRA, 2007 and who does not have access to the home’s critical incident reporting system (and who is not reporting on behalf of the licensee) should report using the toll-free Action Line # at 1-866-454-0144.

LTCR-CM-06-18

January 4, 2018
<table>
<thead>
<tr>
<th>Type of Incident in LTC Home</th>
<th>Section of O Reg 79/10</th>
<th>How Licensee must submit report to MOH/LTC (Director)</th>
<th>Reporting Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition</td>
<td>s.107(3).1</td>
<td>Initiate and submit the on-line CIS form identifying this as a 'Critical Incident'</td>
<td>Same as Monday-Friday</td>
</tr>
<tr>
<td>An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including: A breakdown or failure of the security system, A breakdown of major equipment or a system in the home, A loss of essential services, or flooding</td>
<td>s.107(3).2</td>
<td>Initiate and submit the on-line CIS form identifying this as a 'Critical Incident'</td>
<td>Same as Monday-Friday</td>
</tr>
<tr>
<td>A missing or unaccounted for controlled substance.</td>
<td>s.107(3).3</td>
<td>Initiate and submit the on-line CIS form identifying this as a 'Critical Incident'</td>
<td>Same as Monday-Friday</td>
</tr>
<tr>
<td>Subject to subsection (3.1) [see below], an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change** in the resident’s health condition.</td>
<td>s.107(3).4</td>
<td>Initiate and submit the on-line CIS form identifying this as a 'Critical Incident'</td>
<td>Same as Monday-Friday</td>
</tr>
</tbody>
</table>

| A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. | s.107(3).5 | Initiate and submit the on-line CIS form identifying this as a 'Critical Incident' | Same as Monday-Friday | Within one business day of the incident; full report within 10 days of becoming aware of the incident* |

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* Using the Critical Incident System, the full report under subsection 107(4) of the Regulation must be made within 10 days of the licensee becoming aware of the incident or at an earlier date if required by the Director.

** In section 107 of the Regulation, "significant change" means a major change in the resident’s health condition that:
  1. will not resolve itself without further intervention,
  2. impacts on more than one aspect of the resident’s health condition, and
  3. requires an assessment by the interdisciplinary team or a revision to the resident’s plan of care. [s.107(7)]

Regulation, subsection 107(4.1):
Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident’s condition, the licensee shall:

- Contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident’s health condition; and
- Where the licensee determines that the injury has resulted in a significant change in the resident’s health condition or remains unable to determine whether the injury has resulted in a significant change in the resident’s health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4) [s.107(3.1)]

Regulation, subsection 107(2) - reporting after hours:
Normal business hours of MOH are 8:30 a.m. - 4:30 p.m. After normal business hours, the immediate report of the above incidents must be made using the Ministry’s after-hours emergency contact [SAC]. This pager number is only to be used by LTC Home licensee/staff and only for purposes of after-hours reporting.